Checklist of Pre-Work Activities

- ☐ Select and engage a primary care or mental health organization partner
- ☐ Establish a partnership approach (i.e., how organizations will structure their teams to achieve integrated primary care and mental health services)
- ☐ With assistance from the CPCI Director, identify team members and roles and complete the team roster
- ☐ Develop an aim statement, with the assistance of Pilot-Collaborative leadership, and submit to Director for review and comments
- ☐ Distribute this manual to all team members from both partner organizations
- ☐ Hold first team meeting and make decisions about team roles and regular meeting time
- ☐ Define a pilot population with the assistance of Pilot-Collaborative leadership
- ☐ Discuss key required measures with team members and select additional measures, as required or desired
- ☐ Complete a survey concerning clinical information systems and information technology capability
- ☐ Complete the Assessment of Chronic Illness Care (ACIC) as instructed by the Director
- ☐ Register the team for Learning Session #1. Information will be sent to you through the listserv.
- ☐ Sign up all team members for the listserv
- ☐ Prepare and bring a storyboard, using the format provided to you via email by the Director, to Learning Session #1 for presentation
- ☐ With the assistance of Pilot-Collaborative leadership, plan for implementation of a Clinical Information System

Establishing a Partnership

Several factors may drive selection of a primary care or mental health provider partner, including but not limited to:

- Existing relationships between organizations;
- Proximity between provider sites;
- Focus on a particular patient/client population (e.g., homeless, veterans, racial or ethnic group); or
- Innovation such as demonstrated success using a clinical information system or electronic health record or improved health outcomes resulting from use of evidence-based treatment practices.

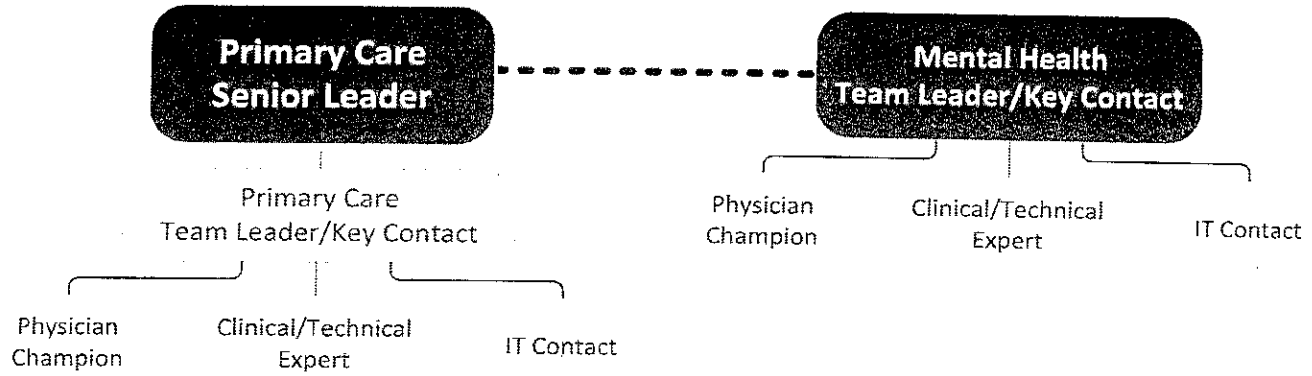
Selection of a partner organization may drive the integration model(s) employed or may assist in narrowing the scope of the organizations' pilot-collaborative aim. During the Pre-Work phase, teams will have the opportunity to hear from each other about the rationale behind partnership decisions as well as key considerations for selecting partners.

Forming Teams

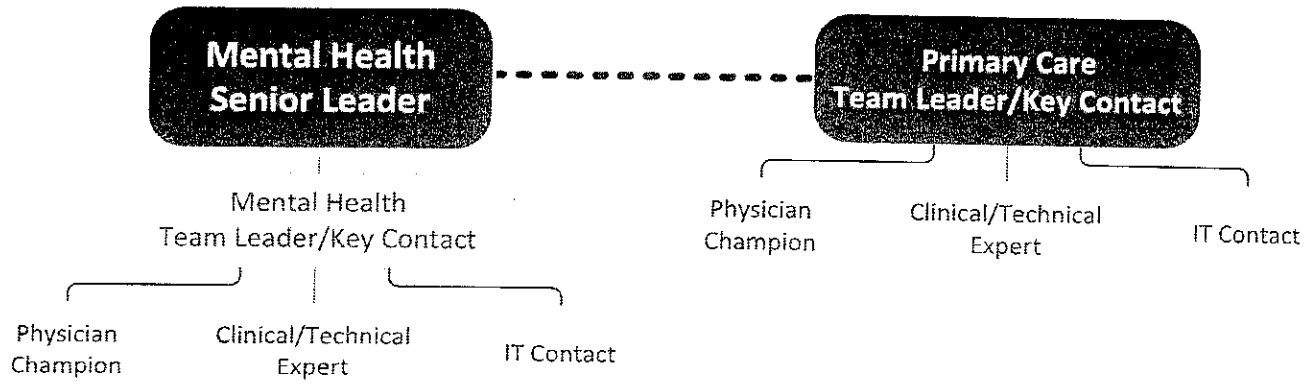
Establishing a partnership with a primary care or mental health provider may also drive the configuration of team members within and across organizations. Having an appropriate and effective team is a key component of successful

improvement efforts. While team configuration may vary across partnerships, some core team roles are required to participate from each organization. Examples of team structures include:

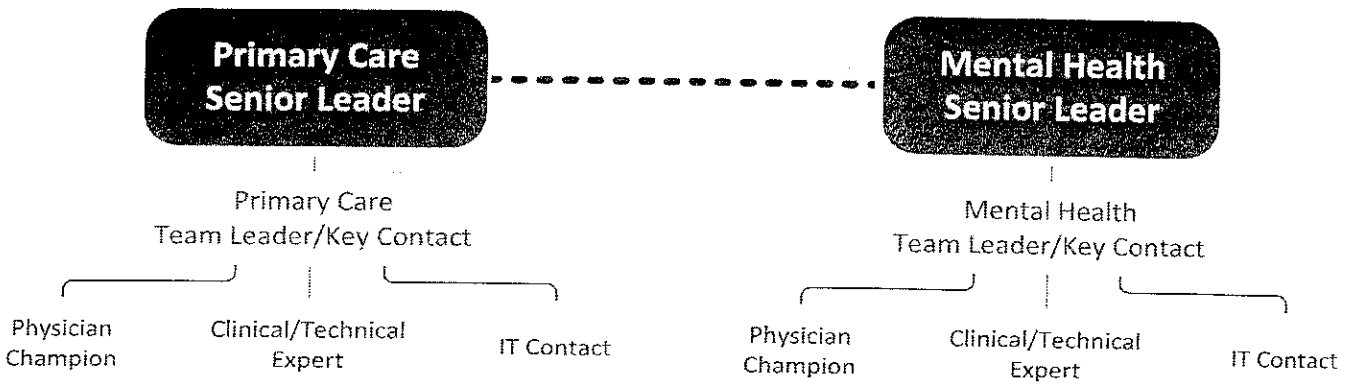
1. **Primary Care Lead Agency** – Leadership from the primary care organization serves as the interagency team lead. Team members are comprised of staff from both the primary care and mental health organization.



2. **Mental Health Lead Agency** – Leadership from the mental health organization serves as the interagency team lead. Team members are comprised of staff from both the primary care and mental health organization.



3. **Joint Primary Care/Mental Health Leadership** – Leadership from both the primary care and mental health organization share responsibility for managing and directing the initiative. Team members are comprised of staff from both the primary care and mental health organization.



A **Change Package** is a collection of change concepts and key change ideas that teams may test to implement change. **Change Concepts** are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes; **Change Ideas** are actionable, specific, and can be tested to determine whether they result in improvements in the local environment. Actual changes that primary care and mental health organizations test will vary. Some ideas are listed below:

Health Care Organization - Create a culture, organization, and mechanisms that promote safe, high quality care:

- Partner each MH organization with a PC clinic to develop a continuum of care
- Establish routine methods to collaborate on daily operations
- Identify shared patients/clients
- Share data across partnering organizations
- Enhance leadership and governance for integrated services delivery
- Establish staffing and resources to support service integration
- Develop training infrastructure and processes
- Place emphasis on clinical operations, work flows and processes
- Promote organizational "will" around integration
- Create opportunities to enhance reimbursement of integrated PC/MH services
- Assure funding for indicated lab tests ordered by MH that address physical health concerns
- Optimize use of existing coding to maximize coverage
- Anticipate/plan for and support the cultural change critical for collaboration between organizations (all levels of staff, clinical design, client needs)
- Involve all players in the change process to create ownership and commitment to the process

Community Resources and Policies - Mobilize community resources to meet needs of clients/patients:

- Connect clients to community-based programs, such as exercise classes, smoking cessation, nutrition, etc.
- Work with community organizations to provide for safe, accessible places to exercise for MH clients
- Form partnerships with community organizations to develop interventions that fill gaps in needed services

Self-Management Support - Empower and prepare clients/patients to manage their health and health care:

- Use client-completed assessment tools
- Partner with clients in treatment planning
- Jointly develop and use recovery-oriented educational approaches to help clients understand and better deal with their illness(es)
- Help clients become more involved in their mental and physical health recovery
- Host wellness groups or other similar discussion groups on health promotion and prevention
- Involve family members, as appropriate, to promote client health and wellness

Decision Support - Promote clinical care that is consistent with scientific evidence and client preferences:

- Provide real-time support to PC for mental health conditions
- Conduct PC Training on MH screening and awareness
- Develop joint UM/UR committee with MH and PC presence to review shared client cases
- Improve the competencies of PC organizations in providing care to MH clients with physical conditions and risk factors
- Improve the competencies of MH organizations in providing care to clients with physical conditions and risk factors
- Implement shared training to improve competencies of PC and MH staff I providing care of to clients with physical conditions and risk factors
- Embed Evidence Based Guidelines for detection and treatment of metabolic and cardiovascular diseases (for clients with SMI)
- Increase access to clinical decision/educational on line tools

Delivery System Design - Assure the delivery of effective, efficient clinical care and self-management support:

- Develop cross-consultation between clients, MH and PC providers to improve communications
- Establish and implement shared guidelines or protocols
- Develop team-driven care
- PC to provide support of select mental health needs, according to organization's "plan for integration"
- Adjust PC service delivery process to be sensitive to mental health conditions
- Establish group visits in PC and MH for clients with SMI and chronic illness
- Use USPSF practice guidelines for guidance on primary and secondary preventive medical/psychiatric care for clients with mental illness in both PC and MH settings
- Use MH evidence based treatment practices that can be useful in PC settings
- Expand MH scope of services to include some primary care (according to "plan for integration")
- Promote healthy lifestyles and weight management in MH settings
- Expand role of MH case managers to support physical health needs
- Utilize existing databases to inform daily practice
- Develop and implement processes to ensure that clients receive less intensive or more intensive levels of care depending on clients' type or severity of disorder, responsiveness to treatment, etc.

Clinical Information Systems - Organize client and population data to facilitate efficient and effective care:

- Increase sharing of clinical information within the bounds of HIPAA
- Implement a Clinical Information System (registry) in both organizations to collect clinical data on common clients